Specialty and Administrative Services

This section contains payment policies for specialty and administrative services. All providers must follow the administrative rules, medical coverage decisions and payment policies contained in the *Medical Aid Rules and Fee Schedules, Provider Bulletins,* and *Provider Updates*. If there are services, procedures, or text contained in the CPT and HCPCS coding books that are in conflict with the *Medical Aid Rules and Fee Schedules*, the department's rules and policies apply (WAC 296-20-010).

All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811.

CONTENTS

ADMINISTRATIVE CODES

These administrative codes are for use by attending doctors when it is permitted within their scope of practice. This includes doctors of medicine, osteopathic medicine and surgery, chiropractic, naturopathy, podiatry, dentistry, and optometry. See **Appendix G** in the "Washington RBRVS Payment Policies" section for authorization and other information about these CPT and local codes.

99080	Special report requested by the agency or 60 day report. Do not use this code for other forms or reports with assigned codes. See WAC 296-20	$31.93
1026M	Attending physician final report (PFR) form completed at request of insurer. Not payable in addition to office visit on same day.	$31.93
1027M	Loss of Earning Power (LEP) form completion by the attending doctor at the insurer's request	$8.99
1037M	Provide physical capacity or restriction information to employer (State Fund only)	$20.38
1039M	Time Loss Notification Form	$8.99
1040M	Completion of the Report of Industrial Injury or Occupational Disease (Report of Accident (ROA)) form	$24.45
1041M	Reopening application. A fee for an evaluation and management service will be paid for this reopening examination when justified by a report. Diagnostic studies and x-rays associated with the reopening application will be allowed in addition to the fee	$24.45
1046M	Mileage, per mile; allowed when round trip exceeds 14 miles.	$4.08
1048M	Completion of a Doctor's Estimate of Physical Capacities form	$20.38
1051M	Copies of medical records, payable to any provider when requested by the department or Self-Insurer or their representative(s); not payable when required to support billing for services performed, per page*	$0.41

*** Code 1051M is only payable directly to providers providing care or services to an injured worker. It is not payable to commercial copy centers or printers who reproduce records for providers. Fee includes all costs including postage.**

1055M	Detailed occupational disease history. Payable only to attending doctors	$154.01
1056M	Supplemental Medical Report (SMR)	$15.10
1057M	Opioid progress report supplement	$15.10
1063M	Attending doctor's review of an independent medical exam (with report) that was requested by the department or Self-Insurer	$32.60
1064M	Initial report documenting need for opioid treatment	$31.93

REVIEW OF JOB OFFERS AND JOB ANALYSES

A **job offer** is an employer's written statement about a specific job the employer is offering to a worker. It is a request for a worker to return to work at a job ***other than*** the job of injury. The job

offer must include a job description, but does not need to include a job analysis. A job offer ***is not*** a request from the employer to release the worker to return to his or her usual or modified job duties.

A **job analysis** is a detailed evaluation of a specific job or type of job. The job may or may not be offered to the worker and it may or may not be linked to a specific employer. A job analysis is used during vocational services to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience and physical limitations.

Only attending doctors will be paid for review of job offers or job analyses (JAs). JA reviews may be performed at the request of the State Fund employer, the insurer, a vocational rehabilitation counselor (VRC), or third party administrator (TPA) acting for the insurer or the employer. JA reviews requested by other persons (e.g. attorneys or injured workers) will not be paid. This service does not require prior authorization and is payable in addition to other services performed on the same day. Refer to Provider Bulletins 99-02 and 99-03 for more information about job offers and job analyses.

1038M	First JA review performed	$31.93
1028M	Each additional JA reviewed on the same day (Limited to a maximum of 5 additional JA reviews per claimant per day)	$15.96

If more than 6 JAs are reviewed on one day, bill one unit for the first one with 1038M. Bill the actual number of additional reviews in the units column of the bill form with 1028M, even though no more than 5 will be paid.

AFTER HOURS SERVICES

These CPT codes are only payable to attending doctors and are payable in addition to other services only when the provider's office is not regularly open during the time the service is provided. Only one service is payable per day.

99050	Medical services after hrs	$17.36
99052	Medical services at night	$24.80
99054	Medical services, unusual hrs	$24.80

AUDIOLOGY SERVICES

A physician's prescription is required and prior authorization must be obtained from the department or Self-Insurer for all hearing related services and devices, in accordance with WAC 296-20-03001 and WAC 296-20-1101.

HEARING AID REPLACEMENT POLICY

The department will only replace hearing aids when a defective hearing aid cannot be repaired or when the department determines that an injured worker's hearing loss has worsened ***due to continued on-the-job exposure***.

If an injured worker's hearing loss worsens and the hearing aid is no longer effective for the hearing loss, a new claim must be filed. If the new degree of hearing loss was due to continued on-the-job exposure, the claim can be accepted. If the increased loss is ***not*** due to on-the-job noise exposure the claim will be denied. The department does ***not*** pay for new hearing aids for: hearing loss

resulting from noise exposure that occurs ***outside*** the workplace, non-work related diseases and conditions, or the natural aging process.

REPAIRS AND WARRANTIES

Hearing aid industry standards provide a minimum of a one-year warranty on most hearing aid devices, **including parts and labor**. The department or Self-Insurer will **not** pay for any repairs within the first twelve months.

The department will repair the hearing aid when the repair is related to normal wear or a work related incident that causes the unit to fail. The department at its sole discretion may authorize the replacement of a hearing aid in lieu of repairing the unit.

Providers **must** indicate in the medical or office record the length of the manufacturer's warranty and what it covers. This information **must** be submitted to the insurer for all hearing aid devices and hearing aid repairs provided to injured workers.

Some wholesale companies also include a replacement policy to pay for lost hearing aids. If the wholesaler/manufacturer includes loss under its warranty, the provider must honor the warranty and replace the worker's lost hearing aid without charge.

The department may replace the hearing aid exterior (mold) when an injured worker has ear canal changes or the mold is cracked. The department will not pay for a new set of hearing aids when only a new ear mold is needed.

Injured workers who lose or damage their hearing aids in **non-work related** accidents or mishaps are responsible for the expenses associated with these types of losses or damages when the manufacturer's warranty expires.

AUDIOLOGY BILLING CODES

All hearing aids and supplies must be billed using the following local codes. The department will only purchase the hearing aids described in these local codes. **The department does not purchase 100% digital hearing aids.**

5060V	6 month repair	$125.68
5061V	Repair hearing aid replate	$151.72
5062V	Repair hearing aid recase	$149.46
5063V	Repair of hearing aid remote device	$141.54
5064V	Repair of programmable hearing aid	$144.94
5065V	Hearing testing	$63.49
5066V	Body worn hearing aid	$696.52
5067V	Bone conduction hearing aid	$765.34
5068V	ITE-full shell hearing aid	$692.35
5069V	ITE-high frequency hearing aid	$769.51
5070V	In the canal & mini canal hearing aid	$942.60
5071V	ITE programmable hearing aid	$1,545.28
5072V	CIC Linear/Compression hearing aid	$1,259.58

5073V	CIC Programmable with or w/o remote	$2,154.22
5074V	BTE Linear hearing aid	$629.79
5075V	BTE Compression hearing aid	$913.41
5076V	BTE Programmable hearing aid	$1,274.18
5077V	BTE High Frequency hearing aid	$755.96
5078V	Glasses, monaural hearing aid	$777.85
5079V	Glasses, bone conduction	$1,028.10
5080V	ITE CROS hearing aid	$1,107.35
5081V	BTE CROS hearing aid	$1,332.57
5082V	Glasses, CROS hearing aid	$1,055.21
5083V	ITE BICROS hearing aid	$1,142.80
5084V	BTE BICROS hearing aid	$1,420.16
5085V	Glasses, BICROS hearing aid	$1,026.02
5086V	Hearing aid batteries, per cell	$1.04
5087V	Hearing aid cleaning kit, includes solution/brush	$10.43
5088V	Miscellaneous hearing aid supplies	BR

BIOFEEDBACK SERVICES

The local codes listed below are for use by approved biofeedback providers only. For further information refer to WAC 296-21-280 and the "Washington RBRVS Payment Policies" section.

1042M	Biofeedback initial evaluation, one hour. Includes report	$122.23
1043M	Biofeedback follow-up evaluation, 30 minutes. Includes report	$61.11

Biofeedback requires prior authorization and has limited treatment spans. Refer to WAC 296-20-03001 for further information.

Rental of home biofeedback devices are time limited and require prior authorization. Refer to WAC 296-20-1102 for more information.

CHIROPRACTIC PHYSICIANS

This section contains billing codes and policies specific to chiropractic physicians. Chiropractic physicians should use the codes listed in this section to bill for services. In addition, chiropractic physicians should use the appropriate CPT codes for radiology, office visit, and case management services and the appropriate HCPCS codes for miscellaneous materials and supplies.

The department will not pay chiropractic physicians for additional codes that are not specifically allowed. Refer to the appendices in the "Washington RBRVS Payment Policies" section for lists of bundled and non-covered codes.

EVALUATION AND MANAGEMENT

Chiropractic physicians may bill the first three levels of CPT new patient office visits codes (99201-99203) and the first four levels of CPT established patient office visit codes (99211-99214). The department uses the CPT definitions for evaluation and management services (E/M) and *new* and *established patients*. If a provider has treated a patient for any reason within the last three years, the person is considered an *established patient*. (See CPT for complete code descriptions, definitions, and guidelines.)

New Patient E/M Payment Policies

The following payment policies apply when chiropractic physicians use E/M new patient office visit codes for the initial visit for a new work injury:

- A new patient E/M office visit code is payable only once for the initial visit.
- Modifier -22 is not payable with E/M codes for chiropractic services.
- New patient E/M office visit codes are payable with L&I chiropractic care codes **only when all of the following conditions are met**:
    - the E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included in the chiropractic care visit, and
    - modifier -25 is added to the new patient E/M code, and
    - supporting documentation describing the service(s) provided is included in the patient's record.

Established Patient E/M Payment Policies

The following payment policies apply when chiropractic physicians use E/M established patient office visit codes:

- An established patient E/M office visit code is not payable on the same day as a new patient E/M office visit code.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 is not payable with E/M codes for chiropractic services.
- Established patient E/M codes are not payable in addition to L&I chiropractic care codes for follow-up visits.
- Established patient E/M codes are payable in addition to L&I chiropractic care codes **only when all of the following conditions are met:**
    - the E/M service is for the **initial visit** for a **new claim**, and
    - the E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included in the chiropractic care visit, and
    - modifier -25 is added to the E/M code, and
    - supporting documentation describing the service(s) provided is included in the patient's record.

When a patient requires re-evaluation for an existing claim, either an established patient E/M CPT code (99211-99214) or a chiropractic care local code (2050A-2052A) is payable. Payment will not be made for both. Modifier -25 is not applicable in this situation.

The department has developed the following clinical complexity based local codes for chiropractic care visits. CPT codes for chiropractic manipulative treatment (codes 98940-98943) are **not covered**.

2050A Level 1: Chiropractic Care Visit (straightforward complexity).....$34.56
2051A Level 2: Chiropractic Care Visit (low complexity) $44.27
2052A Level 3: Chiropractic Care Visit (moderate complexity) $53.93

Chiropractic care visits are defined as office or other outpatient visits involving subjective and objective assessment of patient status. The table below outlines the treatment requirements, presenting problems and face-to-face patient time involved in the three levels of chiropractic care visits.

Clinical decision making complexity is the primary component in selecting the level of chiropractic care visit. The department defines clinical decision making complexity according to the definitions for medical decision making complexity in the *Evaluation and Management Services Guidelines* section of CPT.

	2050A: Level 1	**2051A: Level 2**	**2052A: Level 3**
Primary: Clinical Decision Making Complexity is Typically:	Straightforward	Low complexity	Moderate complexity
Typical number of body regions* manipulated	Up to 2	Up to 3-4	Up to 5 or more
Presenting problems are typically	Self-limiting or minor	Low to moderate severity	Moderate to high severity
Typical face-to-face time with patient and/or family	Up to 10-15 minutes	Up to 15-20 minutes	Up to 25-30 minutes

* The department defines "body regions" as:

- Cervical (includes atlanto-occipital joint);
- Thoracic (includes costovertebral and costotransverse joints);
- Lumbar;
- Sacral;
- Pelvic (includes sacro-iliac joint); and
- Extraspinal: Any and all extraspinal manipulations are considered to be one region. Extraspinal manipulations include head (including temporomandibular joint, excluding atlanto-occipital), lower extremities, upper extremities, rib cage (excluding costotransverse and costovertebral joints).

The following examples of chiropractic care visits are for illustrative purposes only. They are **not** intended to be clinically prescriptive.

Examples:

Level 1 Chiropractic Care Visit (straightforward complexity)

26-year-old male presents with mild low back pain of several days duration. Patient receives manipulation/adjustment of the lumbar region.

Level 2 Chiropractic Care Visit (low complexity)

55-year-old male presents with complaints of neck pain, midback and lower back pain. Patient receives 5 minutes of myofascial release prior to being adjusted. The cervical, thoracic and lumbar regions are adjusted.

Level 3 Chiropractic Care Visit (moderate complexity)

38-year-old female presents with headache, right anterior rib pain, low back pain with pain at the sacrococcygeal junction, as well as pain in the sacroiliac regions and right sided foot drop. Patient receives 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/adjustment to the cervical and atlanto-occipital, thoracic, anterior rib area, lumbar, sacroiliac and sacrococcygeal regions.

CHIROPRACTIC CARE VISIT PAYMENT POLICIES

- Only **one** chiropractic care visit code is payable per day.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 will be individually reviewed when billed with chiropractic care visit local codes (2050A to 2052A). A report is required detailing the nature of the unusual service and the reason it was required. Payment will vary based on findings of the review. No payment will be made when this modifier is used for non-covered or bundled services (for example: application of hot or cold packs).
- Chiropractic care visit codes are payable in addition to E/M office visit codes **only when all of the following conditions are met:**
    - the E/M service is for the **initial visit** for a **new claim,** and
    - the E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included in the chiropractic care visit, and
    - modifier -25 is added to the new patient E/M code, and
    - supporting documentation describing the service(s) provided is included in the patient's record.
- When a reopening application is filed, the services required to complete the application will be paid regardless of the insurer's action on the application:
    - When performed on the same date as completion of the reopening application (local code 1041M), an E/M visit (with -25 modifier when a chiropractic treatment code is also billed) and covered diagnostic studies (including x-rays) will be paid.
    - Treatment procedures on the same date and subsequent to the application date will only be paid if the claim is reopened, as no treatment is payable on denied reopenings (closed claims).

COMPLEMENTARY AND PREPARATORY SERVICES

Chiropractic physicians are not separately paid for patient education or complementary and preparatory services. The department defines complementary and preparatory services as interventions that are used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment.

For example:

> Routine patient counseling regarding lifestyle, diet, self-care and activities of daily living, thermal modalities or some soft tissue work, exercise instruction involving a provision of a sheet of home exercises and a description in the course of a routine office visit.

PHYSICAL MEDICINE TREATMENT

The CPT physical medicine codes (97001-97799) are not payable to chiropractic physicians.

Chiropractic physicians may bill for up to six physical medicine visits using local code 1044M. After six visits the patient must be referred to a licensed, registered physical therapist or physiatrist, except when the chiropractic physician practices in a remote location where no licensed, registered physical therapist or physiatrist is available.

1044M	Physical medicine modality(ies) and/or procedure(s) by the attending doctor who is not board qualified or certified in physical medicine and rehabilitation. Limited to first six visits, except when a doctor practices in a remote area	$ 33.98

CASE MANAGEMENT

Chiropractic physicians should use CPT codes 99361-99373 to bill for case management services. These codes may be paid in addition to other services performed on the same day.

See the "Washington RBRVS Payment Policies" section for criteria on billing case management services.

CONSULTATIONS

Approved chiropractic consultants may bill the first three levels of CPT office consultation codes (99241-99243). The department annually publishes a Provider Bulletin describing the department's policy on consultation referrals. This bulletin also includes a list of approved chiropractic consultants. To obtain the most recent bulletin, call the department's Provider Hotline (1-800-848-0811).

CHIROPRACTIC INDEPENDENT MEDICAL EXAMINATIONS

Chiropractic physicians must be on the Approved Examiners List to perform independent medical examinations (IMEs). To be considered for placement on the Approved Examiners List, a chiropractic physician must have all of the following:

- two years experience as a chiropractic consultant on the department's approved consultant list,
- successfully completed the department's annual disability rating course for Washington state,
- attended the department's annual Chiropractic Consultant Seminar during the previous 12 months,
- submitted the written examination required for certification.

For more information, refer to the *Medical Examiners' Handbook* (publication #F252-001-000).

Chiropractic physicians performing impairment ratings on their own patients or upon referral should refer to the *Medical Examiners' Handbook* and "Impairment Rating by Attending Doctors/Consultants" later in this section.

SUPPLIES

Chiropractic physicians should bill for supplies according to the policies in the "Washington RBRVS and Payment Policies" section.

Ice packs, ice caps and collars are not separately payable. The application of heat or cold is considered a complementary and preparatory service and is not separately payable.

RADIOLOGY SERVICES

Chiropractic physicians should bill diagnostic x-ray services using CPT radiology codes. Billing codes, modifiers, and supporting policies are listed in the "Washington RBRVS Payment Policies" section.

If needed, x-rays immediately prior to and immediately following the initial chiropractic adjustment may be allowed without prior authorization. X-rays subsequent to the initial study require prior authorization.

Only chiropractic physicians who are on the department's list of approved radiological consultants may bill for x-ray consultation services. To qualify, a chiropractic physician must be a Diplomate of the American Chiropractic Board of Radiology, and must be approved by the department.

HOME HEALTH SERVICES

Attendant services providers, home health care providers, nursing homes, hospices and other residential care facilities should use the local codes listed in this section to bill for services. All attendant, home health and residential care services require prior authorization. The insurer will pay only for proper and necessary care and supplies needed because of physical restrictions caused by the industrial injury or disease. The insurer will not pay for codes that are not specifically authorized.

Chore services "and other services required to meet the worker's environmental needs are not covered except for home hospice care.

ATTENDANT SERVICES

Attendant services are proper and necessary personal care services provided to maintain the injured worker in his or her residence. To be covered by the department, attendant services must be requested by the attending physician and authorized by the department before care begins.

Attendant services providers must be at least 18 years old. The department will determine the maximum hours of authorized attendant services based on an independent nursing assessment of the worker's care needs. The insurer will pay a maximum of 70 hours of approved care per provider per week. When a worker's care needs exceed 70 hours per week, additional provider(s) may be approved. Exceptions to this limit can be made upon review by the insurer. Refer to WAC 296-20 for additional information.

8901H Attendant services, non-agency, self-employed (per hour) $10.72

HOME HEALTH AND HOSPICE CARE

Approved hours will be based on health care assessments and review by the insurer. Respite care must be approved in advance. Chore services and other services required to meet the worker's environmental needs are not covered except for home hospice care.

The following are examples of **covered** home health care services:

- Administration of medications which can't be self-administered
- Assistance with range of motion exercises
- Bathing and personal hygiene
- Bowel and bladder care
- Changing or caring for IV's or ventilators (Only family members or licensed persons may perform these services)
- Dressing assistance
- Feeding assistance (not meal preparation)
- Mobility assistance including toileting and other transfers, walking
- Specialized skin care including caring for or changing dressings or ostomies
- Tube feeding
- Turning and positioning

The following services are considered to be "chore services" and are **not covered (except for hospice care)**:

- Child care
- Errands for the injured worker
- Housecleaning
- Laundry
- Meal preparation and shopping
- Transportation
- Recreational activities
- Yard work
- Other everyday environmental needs unrelated to the medical care of the injured worker

Agency Home Health Care

8907H	Home health agency visit (RN) (per day)	$125.28
8912H	Home health agency visit (RN) each additional visit (per day)	$52.68
G0151	Services of physical therapist in home health setting, each 15 minutes (1 hour limit per day)	$31.32
G0152	Services of occupational therapist in home health setting, each 15 minutes (1 hour limit per day)	$32.45
G0153	Services of speech and language pathologist in home health setting, each 15 minutes (1 hour limit per day)	$32.45
G0156	Services of home health aide in home health setting, each 15 minutes (1 hour limit per day)	$5.45
S9124	Nursing care, in the home; by licensed practical nurse, per hour	$34.64
S9126	Hospice care, in the home, per diem	BR

Nursing Evaluations

Periodic independent nursing evaluations may be requested by the insurer. These services require prior authorization. Staffing evaluations required as part of the home health care plan are not payable as separate services.

8913H Independent RN evaluation requested by the department or Self-Insurer including travel and report $413.48

NURSING HOME, HOSPICE AND RESIDENTIAL CARE

Only licensed nursing homes, hospice or other residential care providers will be paid.

Group homes and other residential care settings may be approved by the insurer on a case by case basis depending on the worker's needs. Assisted living is not a covered service.

Medically necessary skilled nursing care and custodial care are covered for the worker's accepted industrial injury or illness. Daily rate fees are negotiated between the facility and the insurer based on the Medicaid and Medicare rates for services provided. Occupational, physical and speech therapies are included in the daily rate and are not separately payable. Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

8902H Nursing home or residential care (group home or boarding home) ..... BR

8906H Facility hospice care ..... BR

HOME INFUSION THERAPY SERVICES

Prior authorization is required for all scheduled or ongoing infusion therapy services (including supplies) provided in the home (excludes offices, hospitals, and nursing homes). This authorization requirement applies to all home infusion therapy regardless of who performs the service (e.g. physicians, nurses, IV infusion therapy company, pharmacy or home health agency).

Payment for performing home infusion therapy is included with the allowed payment for home health agency nursing services. It may not be billed separately. Injections of medications also may not be billed separately.

Supplies used during home infusion therapy, including infusion pumps, are payable only if authorized, and must be billed with HCPCS codes. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps. Bills for home infusion therapy services and supplies must be billed under the home health agency's L&I provider account number.

Drugs used during home infusion therapy, including injectable drugs, are payable only if authorized and must be billed with the NDC codes, (or UPC codes if no NDC codes are available) under a separate L&I pharmacy provider account number.

IMPAIRMENT RATING BY ATTENDING DOCTORS/CONSULTANTS

These local codes are for use by attending doctors who are doctors of medicine, osteopathic medicine and surgery, chiropractic, podiatry, and dentistry. In accordance with WAC 296-23-267, doctors of naturopathy and optometry may not bill these codes. For more information on impairment rating, refer to the *Medical Examiners' Handbook*.

Referral doctors (consultants) performing impairment ratings must be on the department's list of approved examiners.

1190M	Impairment rating by attending doctor, limited	$211.78
1191M	Impairment rating by attending doctor, standard	$308.06
1192M	Impairment rating by attending doctor, complex	$385.06
1193M	Impairment rating by consultant, limited	$211.78
1194M	Impairment rating by consultant, standard	$308.06
1195M	Impairment rating by consultant, complex	$385.06

INTERPRETER SERVICES

These local codes are for use by interpreters who provide language communication between injured workers and medical or vocational service providers.

Only those eligible to interpret and be paid for interpretive services may bill these local codes. Family members, friends, medical, health care and vocational providers may provide interpretive services, but are not eligible to receive payment. Attorneys, employees of law firms, and agents of the employer of injury are not eligible to interpret or be paid for interpretive services. Refer to Provider Bulletin 99-09 for complete payment and eligibility information.

9980M	Interpreter services, per 15 minutes	$14.65
9981M	Wait time/form completion, per 15 minutes (maximum of 30 minutes per date of service)	$14.65
9982M	Interpreter, IME no show, per 15 minutes (maximum of 30 minutes per date of service)	$14.65
9986M	Interpreter mileage	state rate
9987M	Document translation at insurer request only, per 15 minutes (prior authorization required for each document)	$14.65

MEDICAL TESTIMONY AND DEPOSITIONS

These local codes are for use by any provider requested by the Office of the Attorney General or the Self-Insurer to provide testimony or deposition. Bills for these services should be submitted directly to the Office of the Attorney General or Self-Insurer.

Local codes 1049M, 1050M, 1053M, and 1054M are calculated on a "portal to portal" basis, i.e. from the time you leave your office until you return. This does not include side trips.

The time calculation for testimony or deposition done in the provider's office or via phone is based upon the actual face-to-face time consumed for the testimony or deposition.

1049M	Medical testimony approved in advance by Office of the Attorney General, first hour	$384.41
1050M	Each additional 30 minutes	$128.14
1053M	Deposition approved in advance by Office of Attorney General, first hour	$320.35
1054M	Each additional 30 minutes	$107.31

NATUROPATHIC PHYSICIANS

Naturopathic physicians should use the local codes listed in this section to bill for office visit services, CPT codes 99361-99373 to bill for case management services and the appropriate HCPCS codes to bill for miscellaneous materials and supplies.

Codes for supplies and materials that do not have a fee listed will be paid at their *acquisition cost*. An invoice must be retained in provider files for all supplies. For supplies costing $150.00 or more, a copy of the invoice must be submitted with the bill. Sales tax and delivery charges are not separately payable, and should be included in the total charge for the supply. When billing for taxable items, an itemized invoice may be attached showing price plus tax, but is not required.

The department will not pay naturopathic physicians for additional codes that are not specifically allowed. Refer to WAC 296-23 for additional information.

INITIAL VISITS

2130A	Routine examination, history, and/or treatment (routine procedure), and submission of a report	$43.18
2131A	Extended office visit including treatment - report required	$64.78
2132A	Comprehensive office visit including treatment - report required in addition to the report of accident	$86.39

FOLLOW-UP VISITS

2133A	Routine office visit including evaluation and/or treatment	$34.56
2134A	Extended office visit including treatment - report required	$64.78

NURSE CASE MANAGEMENT SERVICES

All nurse case management services require prior authorization. Refer to Provider Bulletin 98-01 for a complete description of the services, provider qualifications and billing instructions.

The following local codes and fees apply to nurse case management services:

1220M	Phone calls per 6 minute unit	$8.09
1221M	Visits per 6 minute unit	$8.09
1222M	Case planning per 6 minute unit	$8.09
1223M	Travel/Wait per 6 minute unit	$3.98
1224M	Mileage per mile	state employee rate
1225M	Expenses (parking, ferry, toll fees, lodging and airfare) at cost or state per diem rate (lodging)	

Nurse case management services are capped at 50 hours of service including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases contingent upon review by the insurer.

OBESITY TREATMENT

While obesity does not meet the definition of an industrial injury or occupational disease, temporary treatment of obesity may be allowed in some cases. All obesity treatment services require prior authorization. Refer to Provider Bulletin 97-03 for more information.

The attending doctor may request a consultation with a certified dietician or nutritionist (RD) to determine if an obesity treatment program is appropriate for the injured worker. The following local codes are payable only to RD's:

1030M	Obesity treatment; intake dietary evaluation (limited to one per obesity treatment program)	$77.43
1034M	Obesity treatment; dietary re-evaluation (limited to 3 per obesity treatment program)	$53.09

PATHOLOGY AND LABORATORY SERVICES

PANEL TESTS

Automated Multichannel Tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both. CPT has defined the following tests as automated multichannel tests or panels comprised solely of automated multichannel tests:

CPT Code	Abbreviated Description
80048	Basic metabolic panel
80051	Electrolyte panel
80053	Comprehensive metabolic panel
80069	Renal function panel
80076	Hepatic function panel
82040	Assay of serum albumin
82247	Bilirubin, total
82248	Bilirubin, direct
82310	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82465	Assay of serum cholesterol
82550	Creatine kinase (CK) (CPK)

CPT Code	Abbreviated Description
82565	Assay of creatinine
82947	Assay of glucose, quantitative
82977	Assay of GGT
83615	Lactate (LD) (LDH) enzyme
84075	Assay alkaline phosphatase
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84450	Transferase (AST) (SGOT)
84460	Alanine amino (ALT) (SGPT)
84478	Assay of triglycerides
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid

Payment Calculation for Automated Tests

The automated individual and panel tests listed above will be paid based on the total number of unduplicated automated multichannel tests performed per day per patient. Payment calculation is made according to the following steps:

- When a panel test is performed, the CPT codes for each test within the **panel** are determined.
- The CPT codes for each test in the **panel** are compared to any individual tests billed separately for that patient for that day.

- Any duplicated tests are denied.
- Then the total number of remaining unduplicated automated tests are counted. See the following table to determine the payable fee based on the total number of unduplicated automated tests performed:

Number of Tests	Fee
1 test	Lower of the single test fee or $ 10.08
2 tests	$10.08
3-12 tests	$12.36
13-16 tests	$16.51

Number of Tests	Fee
17-18 tests	$18.49
19 tests	$21.39
20 tests	$22.09
21 tests	$22.78
22 to 23 tests	$23.48

Payment Calculation for Panels with Automated and Non-Automated Tests

When panels are comprised of both automated multichannel tests and individual non-automated tests, they will be priced based on:

- the automated multichannel test fee based on the number of tests, added to:
- the sum of the fee(s) for the individual non-automated test(s).

For example, panel test 80061 is comprised of two automated multichannel tests and one non-automated test. As shown below, the fee for 80061 is **$25.91**.

80061 Component Tests		Number of Automated Tests	Fee	
Automated:	82465 84478	2	Automated:	$10.08
Non-Automated:	83718		Non-Automated:	$15.83
		TOTAL FEE:	**$25.91**	

Payment Calculation for Multiple Panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be limited to the total fee allowed for the unduplicated component tests.

For example, if panel codes 80050, 80076 and 80090 are performed on the same day, for the same patient, the fee for the tests will be **$165.75**. This fee is based on the fee for the 15 unduplicated automated multichannel tests, and the sum of the fees for the six unduplicated non-automated tests.

80050 Component Tests	80076 Component Tests	80090 Component Tests	Number of Unduplicated Automated Tests	Fee
Automated: 82040 82247 82310 82374 82435 82565 82947 84075 84132 84155 84295 84450 84460 84520	Automated: 82040 ** 82247 ** 82248 84075 ** 84155 ** 84450 ** 84460 **	Automated: none	15	Automated: $16.51
Non-Automated: 84443 85025 *	Non-Automated: None	Non-Automated: 86644 86694 86762 86777		Non-Automated: $32.40 $15.04 $25.45 $25.45 $25.45 $25.45
			TOTAL FEE:	**$165.75**

* 80050 specifies that either 85022 or 85025 is performed; this example uses 85025

** Duplicated tests

REPEAT TESTS

Additional payment will be allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) must be taken from separate encounters. Test(s) normally performed in a series, e.g. glucose tolerance tests, or repeat testing of abnormal results do not qualify as separate encounters. The medical necessity for repeating the test must be documented in the patient's record.

Modifier -91 must be used to identify the repeated test(s). Payment for repeat panel tests or individual components tests will be made based on the methodology described above.

SPECIMEN COLLECTION AND HANDLING

Specimen collection charges are allowed for physician, independent laboratory or outpatient hospital laboratory services as follows:

- The fee is payable only to the provider (physician or laboratory) who actually draws the specimen.
- Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee who is qualified to do specimen collection performs the draw.
- Payment for performing the test is separate from the specimen collection fee.

- Costs for media, labor and supplies (e.g. gloves, slides, antiseptics, etc.) are included in the payment for the specimen collection.
- A collection fee is not allowed when the cost of collecting the specimen(s) is minimal, such as a throat culture, Pap smear or a routine capillary puncture for clotting or bleeding time.
- No fee is payable for specimen collection performed by patients in their homes (such as stool sample collection).

Use CPT code 36415 or HCPCS code G0001 for venipuncture. Use HCPCS code P9612 or P9615 for catheterization for collection of specimen.

Complex vascular injection procedures, such as arterial punctures and venisections are not subject to this policy and will be paid with appropriate CPT or HCPCS codes.

No payment for travel will be made to nursing home or skilled nursing facility staff who perform the specimen collection. Travel will be paid in addition to the specimen collection fee when **all** of the following conditions are met:

- it is medically necessary for a physician or laboratory technician to draw a specimen from a nursing home, skilled nursing facility or homebound patient, and
- the physician or lab technician personally draws the specimen, and
- the trip is solely for the purpose of collecting the specimen. If the specimen draw is incidental to other services, no travel is payable.

Use HCPCS code P9603 to bill for actual mileage (one unit equals one mile). HCPCS code P9604 is not covered.

Payment will not be made for handling and conveyance, e.g. shipping or messenger or courier service of specimen(s) (CPT codes 99000 and 99001). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These services are considered to be integral to the testing process and are bundled into the total fee for the testing service.

STAT LAB FEES

Usual laboratory services are covered under the RBRVS fee schedule. In cases where laboratory tests are appropriately performed on a STAT basis, the provider may bill local code 8949M. Payment will be limited to one STAT charge per episode (not once per test). Tests ordered STAT should be limited to only those that are needed to manage the patient in a true emergency situation. The laboratory report should contain the name of the provider who ordered the STAT test(s). The medical record must reflect the medical necessity and urgency of the service.

8949M STAT Laboratory Fee, per episode..... $10.84

The STAT charge will only be paid with the tests listed below.

CPT Code	Abbreviated Description
80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen
80101	Drug screen
80156	Assay of carbamazepine
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay of primidone
80192	Assay of procainamide
80194	Assay of quinidine
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urinalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin, total
82248	Bilirubin, direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases: pH, pO2 & pCO2
82945	Glucose other fluid
82947	Assay of glucose, quant
83615	Lactate (LD) (LDH) enzyme
83663	Fluoro polarize, fetal lung
83664	Lamellar bdy, fetal lung

CPT Code	Abbreviated Description
83735	Assay of magnesium
83874	Assay of myoglobin
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84295	Assay of serum sodium
84450	Transferase (AST) (SGOT)
84484	Assay of troponin, quant
84512	Assay of troponin, qual
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
85007	Differential WBC count
85021	Automated hemogram
85022	Automated hemogram
85023	Automated hemogram
85024	Automated hemogram
85025	Automated hemogram
85027	Automated hemogram
85046	Reticucytes/hgb concentrate
85378	Fibrin degradation
85384	Fibrinogen
85595	Platelet count, automated
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86403	Particle agglutination test
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86971	RBC pretreatment
87205	Smear, stain & interpret
87210	Smear, stain & interpret
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia
87400	Influenza a/b, ag, eia
89051	Body fluid cell count

PHARMACY AND DURABLE MEDICAL EQUIPMENT (DME) PROVIDERS

PHARMACY FEE SCHEDULE

Payment for drugs and medications including all oral non-legend drugs will be based on the pricing methodology described below. Refer to Provider Bulletin 99-10 for more information on the Pharmacy Fee Schedule and WAC 296-20-01002 for definitions of Average Wholesale Price (AWP) and Base Line Price (BLP). The department's outpatient formulary can be found in the Appendix at the end of this chapter.

Generic	The lesser of BaseLine Price™ (BLP) or Average Wholesale Price (AWP) less 10% + $4.50 Professional Fee
Brand with Generic Equivalent (Substitution Allowed)	The lesser of BLP or AWP less 10% + $3.00 Professional Fee
Brand with Generic Equivalent (Dispensed as Written)	AWP less 10% + $4.50 Professional Fee
Single or multi-source brand name drugs	AWP less 10% + $4.50 Professional Fee

Compounded prescriptions will be paid at the allowed cost of the ingredients, a compounding time fee of $4.00 per 15 minutes plus the applicable professional component as indicated above.

Over-The-Counter Items

Orders for over-the-counter non-oral drugs or non-drug items must be written on standard prescription forms. These items are to be priced on a forty percent margin.

Per RCW 82.08.0281 prescription drugs and oral or topical over-the-counter medications are nontaxable.

EMERGENCY CONTRACEPTIVES AND PHARMACIST COUNSELING

Effective November 1, 1998, the department began covering Emergency Contraceptive Pills (ECPs) and associated pharmacist counseling services. These are covered only when **all** of the following conditions are met:

- a valid claim for rape in the workplace is established with the insurer,
- the ECP and/or counseling service is sought by the injured worker,
- the claim manager authorizes payment for the ECP and/or the counseling, and
- the pharmacist is approved by the Department of Health Board of Pharmacy to follow this particular protocol.

Once these conditions have been met, the dispensed medication should be billed with the appropriate NDC, and the counseling service should be billed with local code 4805A. The maximum allowable amount for the counseling is listed below.

4805A ECP counseling by a pharmacist at the time the ECP is dispensed..... $31.90

INFUSION THERAPY SERVICES

Prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic or home, regardless of who performs the service (e.g. physicians, nurses, IV infusion therapy company, pharmacy or home health agency).

Infusion therapy services (CPT codes 90780 and 90781) and/or therapeutic, diagnostic, or vascular injections (CPT codes 90782, 90783, 90784, 90788 and 36000-36640), are not payable to pharmacies and IV infusion companies. If nurses work for these companies providing infusion therapy services, the services must be billed with an L&I home health agency provider account number or an independent registered nurse provider account number.

Supplies used during infusion therapy, including infusion pumps, are payable only if authorized, and must be billed with HCPCS codes. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps. Pharmacies and IV infusion companies must bill for infusion therapy supplies under their L&I provider account numbers.

Drugs used during infusion therapy, including injectable drugs, are payable only if authorized and must be billed with the NDC codes, (or UPC codes if no NDC codes are available) under an L&I pharmacy provider account number.

DURABLE MEDICAL EQUIPMENT

Pharmacies and durable medical equipment providers may bill for supplies and equipment with appropriate HCPCS and local codes (local codes for supplies are listed at the end of this section). Delivery charges, shipping and handling, tax, and fitting fees are not payable separately. DME suppliers should include these charges in the total charge for the supply. For taxable items, an itemized invoice may be attached to the bill, but is not required.

DME suppliers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account number. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps.

TENS units and supplies (transcutaneous electrical nerve stimulators) are paid under special contract only. See "Transcutaneous Electrical Nerve Stimulators (TENS)" later in this section.

For further information on miscellaneous services and appliances, refer to WAC 296-23-165.

BUNDLED CODES

The concept of "bundled" codes does not apply to pharmacy and durable medical equipment providers. This is because there is no office visit or procedure associated with these provider types into which supplies can be bundled. As a result, covered HCPCS codes listed as "Bundled" in the fee schedules are payable to pharmacy and durable medical equipment providers.

PHYSICAL CAPACITIES EVALUATION

The following local code is payable only to physicians who are board qualified or certified in physical medicine and rehabilitation, and physical and occupational therapists.

1045M	Performance-based physical capacities evaluation with report and summary of capacities	$592.15

PHYSICIAN ASSISTANTS

Physician assistants must be certified to qualify for payment. Physician assistants must have valid individual L&I provider account numbers to be paid for services.

Consultations, impairment ratings and administrative or reporting services related to worker's compensation benefit determinations are not payable to physician assistants. Physician assistant services are paid to the supervising physician or employer at a maximum of ninety percent (90%) of the allowed fee.

Further information about physician assistant services and payment can be found in Provider Bulletin 99-04.

POST-ACUTE BRAIN INJURY REHABILITATION

Only programs accredited by the Commission on Accreditation of Rehabilitation Facilsities (CARF) may provide post-acute brain injury rehabilitation services for injured workers. These services require prior authorization. Follow-up care is included in the cost of the full day or half day program. This includes, but is not limited to telephone calls, home visits and therapy assessments. Refer to Provider Bulletins 98-02 and 98-04 for more information.

Non-hospital based programs must bill the following **local** codes:

8950H	Comprehensive brain injury evaluation	$3,487.07
8951H	Post-acute brain injury rehabilitation full day program, per day (minimum of 6 hours per day)	$622.69
8952H	Post-acute brain injury rehabilitation half day program, per day (minimum 4 hours per day)	$373.62

Hospital based programs must bill the following **revenue** codes:

014	Comprehensive brain injury evaluation	$3,487.07
015	Full day program, per day (minimum 6 hours per day)	$622.69
016	Half day program, per day (minimum 4 hours per day)	$373.62

SUPPLY CODES

0420A	Lumbar seat support	BR
0421A	Pressure garments	BR
0426A	Silicone elastomer/scar conformer	BR
0428A	Therapeutic exercise putty	BR
0429A	Rubber exercise tubing	BR
0430A	Anti-vibration gloves (if supplied as part of a job modification, do not bill this code, use the appropriate job modification code)	BR
0010E	Ankle weight purchase	BR
0012E	Wrist weight purchase	BR
1602L	Orthotic impression casting	BR

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

TENS units and supplies for State Fund injured workers are provided under contract. All providers who prescribe TENS units for State Fund injured workers must use the department's contracted vendor.

- TENS use requires prior authorization from the insurer.
- The department allows the initial TENS application and training by a physical therapist or other qualified provider ***only once per claim***. Use CPT code 64550.
- An initial 30-day evaluation period is required. If the TENS is beneficial for the injured worker, a three-month rental period may be approved. One additional three-month rental extension may be granted. At the end of six months, a request for purchase will be considered upon review by the insurer. Refer to the department's Provider Bulletin on TENS for more information about rental and purchase for State Fund claims.
- The department's contracted vendor and providers treating Self-Insured workers should use the appropriate HCPCS codes to bill for TENS units and supplies.
- Sales tax and delivery charges are not separately payable, and should be included in the total charge for the TENS unit and supplies.

HCPCS Code	Description	Coverage Status
A4595	TENS supplies	For State Fund claims: Payable only to the department's contracted vendor. For Self-Insured claims: Payable to DME suppliers.
A4630	Replacement batteries	
E0720	TENS, two lead, localized stimulation	
E0730	TENS, four lead, larger area, multiple nerve stimulation	

VEHICLE, HOME AND JOB MODIFICATIONS

These local and HCPCS codes require prior authorization. Refer to Provider Bulletins 96-11 for home modification information and 99-11 for job modification and pre-job accommodation information.

8914H	Home modification, construction and design	.... maximum payable for all work is the current Washington state average annual wage
8915H	Vehicle modification	..... maximum payable for all work is ½ current Washington state average wage
8916H	Home modification evaluation and consultation	BR
8917H	Home/vehicle modification mileage, lodging, airfare, car rental	..state employees' rates
8918H	Vehicle modification initial evaluation or consultation	BR
8920H	Vehicle modification follow up consultation	BR
0380R	Job modification (equipment etc.) *	
0385R	Pre-job accommodation (equipment etc.) *	
	* Maximum allowable for 0380R and 0385R combined	$5,000.00

VOCATIONAL SERVICES

Vocational Rehabilitation providers should use the codes listed in this section to bill for services. For more detailed information on billing, consult *Miscellaneous Services Billing Instructions*.

All vocational rehabilitation services require prior authorization. Vocational rehabilitation services are authorized by referral type. The five referral types the department uses are: early intervention, assessment, plan development, plan implementation and forensic. **Each referral is a separate authorization for services.**

The department will pay interns at 85% of the VRC professional rate and forensic evaluators at 120% of the VRC professional rate. Hourly rates for professional vocational services are as follows: Vocational Rehabilitation Counselors, $73.00 per hour; Interns $62.00 per hour; and Forensic Evaluators, $88.00 per hour. Please note, however, vocational services **must be billed in six-minute time increments.**

Early Intervention

0800V	Early Intervention Services, VRC (per 6 minutes)	$7.30
0801V	Early Intervention Services, Intern (per 6 minutes)	$6.20

Assessment

0810V	Assessment Services, VRC (per 6 minutes)	$7.30
0811V	Assessment Services, Intern (per 6 minutes)	$6.20

Vocational Evaluation

0821V	Work Evaluation, VRC (per 6 minutes)	$7.30
0823V	Pre-Job or Job Modification Consultation, VRC (per 6 minutes)	$7.30
0824V	Pre-Job or Job Modification Consultation, Intern (per 6 minutes)	$6.20

Plan Development

0830V	Plan Development Services, VRC (per 6 minutes)	$7.30
0831V	Plan Development Services, Intern (per 6 minutes)	$6.20

Plan Implementation

0840V	Plan Implementation Services, VRC (per 6 minutes)	$7.30
0841V	Plan Implementation Services, Intern (per 6 minutes)	$6.20

Forensic and Testimony

0881V	Forensic Services, Forensic VRC (per 6 minutes)	$8.80
0882V	Testimony on VRC's Own Work, VRC (per 6 minutes)	$7.30
0883V	Testimony on Intern's Own Work, Intern (per 6 minutes)	$6.20
0884V	AGO Witness Testimony, VRC (per 6 minutes)	$7.30

Travel, Wait Time, and Mileage

0891V	Travel/Wait Time, VRC, Intern, or Forensic VRC (per 6 minutes)	$3.65
0893V	Professional Mileage, VRC (per mile)	state rate
0894V	Professional Mileage, Intern (per mile)	state rate
0895V	Air Travel, VRC, Intern, or Forensic VRC	BR

Fee Caps

Vocational services are subject to the fee caps. These caps are **hard caps**, with **no exceptions**. The following fee caps are by referral. All services provided for the referral are included in the cap.

Early Intervention Referral Cap	$1,500
Assessment Referral Cap	$2,500
Plan Development Referral Cap	$5,000
Plan Implementation Referral Cap	$4,725

The fee cap for work evaluation services applies to multiple referral types. Total payment for work evaluation services provided under all referral types will not exceed $1,100. For example, if $500 of work evaluation services are paid as part of a plan development referral, only $600 is available for payment under another referral type.

Work Evaluation Services Cap	$1,100

APPENDIX
OUTPATIENT DRUG FORMULARY

The following is a list of the therapeutic classes (TCC) and their status in L&I's formulary. In most cases, the status is class specific rather than drug specific. An example of an exception to this general rule is therapeutic class code TCC - H2D Barbiturates. Phenobarbital is the only drug in the class that L&I will allow.

PLEASE KEEP THE FOLLOWING POINTS IN MIND ABOUT THE FORMULARY

- This is an outpatient formulary. Many of the drugs in the denied category are appropriate for in- and outpatient surgery and emergency room, clinic or office settings, and are covered when billed appropriately.
- Some drugs in the denied category may be allowed under certain circumstances. These will be addressed on a case-by-case basis.
- Utilization of drugs in the authorized category is subject to department policy and appropriateness for the accepted conditions.

KEY TO STATUS AND REPRESENTATIVE DRUG INDICATORS

Status

A = Allowed
PA = Prior Authorization required
D = Denied
O = Other (Will not pay through L&I's Point-of-Sale System)

Representative Drug

Blank = Self-explanatory or used mainly for compound drugs
***** = No drugs currently listed in the therapeutic class

COMPOUND DRUGS

STATUS	TCC	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
PA	000	COMPOUND DRUGS	

A CARDIOVASCULAR SYSTEM

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
PA	A1A	DIGITALIS GLYCOSIDES	LANOXIN
A	A1B	XANTHINES	THEOPHYLLINE
D	A1C	INOTROPIC DRUGS	DOBUTAMINE
A	A1D	GENERAL BRONCHODILATOR AGENTS	BRONKAID MIST
PA	A2A	ANTIARRHYTHMICS	MEXILETINE HCL
PA	A4A	HYPOTENSIVES-VASODILATORS	HYTRIN
PA	A4B	HYPOTENSIVES-SYMPATHOLYTIC	CLONIDINE HCL
PA	A4C	HYPOTENSIVES-GANGLIONIC BLOCKERS	INVERSINE
PA	A4D	HYPOTENSIVES-ANGIOTENSIN CONVERTING ENZYME BLOCKERS	ZESTRIL
PA	A4E	HYPOTENSIVES-VERATRUM ALKALOIDS	*
PA	A4F	HYPOTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	COZAAR
PA	A4Y	HYPOTENSIVES-MISCELLANEOUS	ZIAC
D	A6U	CARDIOVASCULAR DIAGNOSTICS	
D	A6V	CARDIOVASCULAR DIAGNOSTICS - NON RADIOPAQUE	
PA	A7A	ARTERIOLAR VASOCONSTRICTORS	*

PA	A7B	CORONARY VASODILATORS	IMDUR
PA	A7C	PERIPHERAL VASODILATORS	ERGOLOID MESYLATES
PA	A7E	VASODILATORS-MISCELLANEOUS	PROSTIN VR PEDIATRIC
PA	A7F	VEINOTONIC/VASCULOPROTECTORS	*
D	A8O	VENOSCLEROSING AGENTS	ETHAMOLIN
PA	A9A	CALCIUM CHANNEL BLOCKING AGENTS	VERAPAMIL HCL

B RESPIRATORY SYSTEM

STATUS	GC3	DESCRIPTION	REPRESENTATIVE DRUG
A	B0A	MISCELLANEOUS RESPIRATORY INHALANTS	SODIUM CHLORIDE
D	B0P	INERT GASES	
D	B1A	LUNG SURFACTANTS	SURVANTA
A	B3A	MUCOLYTICS	MUCOMYST
A	B3J	EXPECTORANTS	GUAIFENESIN
A	B3K	COUGH AND COLD PREPARATIONS	DIMETAPP
D	B3M	RESPIRATORY TRACT RADIOPAQUE DIAGNOSTICS	

C ELECTROLYTE BALANCING SYS/METABOLIC SYS/NUTRITION

STATUS	GC3	DESCRIPTION	REPRESENTATIVE DRUG
A	C0B	WATER	WATER FOR INHALATION
D	C0C	DRUGS USED TO TREAT ACIDOSIS	THAM
PA	C0D	ANTIALCOHOLIC PREPARATIONS	DISULFIRAM
PA	C0K	BICARBONATE PRODUCING/CONTAINING AGENTS	SODIUM ACETATE
PA	C1A	ELECTROLYTE DEPLETERS	KAYEXALATE
PA	C1B	SODIUM REPLACEMENT	
PA	C1D	POTASSIUM REPLACEMENT	
PA	C1F	CALCIUM REPLACEMENT	
PA	C1H	MAGNESIUM REPLACEMENT	
PA	C1P	PHOSPHATE REPLACEMENT	
PA	C1W	ELECTROLYTE REPLACEMENT	
D	C2H	RESPIRATORY GASES	
PA	C3B	IRON REPLACEMENT	
PA	C3C	ZINC REPLACEMENT	
PA	C3H	IODINE REPLACEMENT	
PA	C3M	MISCELLANEOUS MINERAL REPLACEMENT	
PA	C4G	INSULINS	
PA	C4K	HYPOGLYCEMICS, INSULIN-RELEASE STIM. TYPE	GLYBURIDE
PA	C4L	HYPOGLYCEMICS, BIGUANIDE TYPE (N-S)	GLUCOPHAGE
PA	**C4M**	**HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIB. TYPE (N-S)**	**PRECOSE**
PA	C4N	HYPOGLYCEMICS, INSULIN-RESPONSE ENHANCER (N-S)	REZULIN
PA	C40	HYPOGLYCEMICS, ABSORPTION MODIFIER, USPECIFIED	*
PA	C4P	HYPOGLYCEMICS, UNSPECIFIED MECHANISM	*
PA	C4Q	HYPOGLYCEMICS, COMBINATION	*
PA	C5A	CARBOHYDRATES	DEXTROSE IN WATER
PA	C5B	PROTEIN REPLACEMENT	L-LYSINE
D	C5C	INFANT FORMULAS	ENFAMIL
D	C5D	DIET FOODS	*
D	C5E	GERIATRIC SUPPLEMENTS	SOD-K
D	C5F	MISCELLANEOUS FOOD SUPPLEMENTS	SUSTACAL
D	C5G	FOOD OILS	MCT OIL
A	C5H	NUCLEIC ACID SUPPLEMENTS	ADENOSINE TRIPHOSPHATE
A	C5J	IV SOLUTIONS: DEXTROSE/WATER	
A	C5K	IV SOLUTIONS: DEXTROSE/SALINE	
A	C5L	IV SOLUTIONS: DEXTROSE/RINGERS	
A	C5M	IV SOLUTIONS: DEXTROSE/LACTATED RINGERS	
A	C5O	SOLUTIONS, MISCELLANEOUS	
D	C5Q	TONICS	*
D	C5U	NUTRITIONAL THERAPY, GLUCOSE INTOLERANCE	GLUCERNA
D	C6A	VITAMIN A PREPARATIONS	
D	C6B	VITAMIN B PREPARATIONS	

PA	C6C	VITAMIN C PREPARATIONS	
D	C6D	VITAMIN D PREPARATIONS	
D	C6E	VITAMIN E PREPARATIONS	
D	C6F	PRENATAL VITAMIN PREPARATIONS	
D	C6G	GERIATRIC VITAMIN PREPARATIONS	
D	C6H	PEDIATRIC VITAMIN PREPARATIONS	
D	C6J	BIOFLAVONOIDS	
PA	C6K	VITAMIN K PREPARATIONS	MEPHYTON
PA	C6L	VITAMIN B12 PREPARATIONS	
PA	C6M	FOLIC ACID PREPARATIONS	
D	C6N	NIACIN PREPARATIONS	
D	C6P	PANTHENOL PREPARATIONS	
D	C6Q	VITAMIN B6 PREPARATIONS	
D	C6R	VITAMIN B2 PREPARATIONS	
D	C6T	VITAMIN B1 PREPARATIONS	
D	C6Z	MISCELLANEOUS MULTIVITAMIN PREPARATIONS	
D	C7A	PURINE INHIBITORS	ALLOPURINOL
A	C7B	DECARBOXYLASE INHIBITORS	*
A	C7C	DIPEPTIDASE INHIBITORS	*
D	C7D	METABOLIC DEFICIENCY AGENTS	CYSTADANE
D	C7E	APPETITE STIMULANTS	PERIAVIT
A	C8A	METALLIC POISON ANTIDOTES	CUPRIMINE
A	C8B	ACID AND ALKALI POISON ANTIDOTES	METHYLENE BLUE
A	C8D	AGRICULTURAL POISON ANTIDOTES	PROTOPAM CL
A	C8E	MISCELLANEOUS ANTIDOTES	DIGIBIND

D BILIARY SYSTEM/GASTRO-INTESTINAL SYSTEM

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
D	D0U	GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS	
D	D1A	PERIODONTAL COLLAGENASE INHIBITORS	PERIOSTAT
D	D1D	DENTAL SUPPLIES	TRIAMCINOLONE-ACETONIDE
D	D2A	FLUORIDE PREPARATIONS	PREVIDENT
D	D2D	TOOTH ACHE PREPARATIONS	CLOVE OIL
D	D2M	MISCELLANEOUS DENTAL PREPARATIONS	*
A	D4A	ACID REPLACEMENT	ACIDUTEX
A	D4B	ANTACIDS	MAALOX
A	D4C	AGENTS FOR STOMATOLOGICAL USE	DEBACTEROL
A	D4D	ANTIDIARRHEAL MICROORGANISMS AGENTS	*
A	D4E	ANTIULCER PREPARATIONS	CARAFATE
D	D4F	ANTIULCER -- H. PYLORI AGENTS	HELIDAC THERAPY
A	D4G	GASTRIC ENZYMES	LACTASE
A	D4H	ORAL MUCOSITIS/STOMATITIS AGENTS	ORAKOTE
A	D4I	ORAL MUCOSITIS/STOMATITIS ANTIINFLAMMATORY AGENTS	APHTHASOL
A	D4K	GASTRIC ACID SECRETION REDUCER	PRILOSEC
A	D4N	ANTIFLATULENTS	SIMETHICONE
D	D4T	GASTRIC FUNCTION DIAGNOSTICS	
D	D4U	GASTRIC FUNCTION RADIOPAQUE DIAGNOSTICS	
D	D5A	FAT ABSORPTION DECREASING AGENTS	XENICAL
A	D5P	INTESTINAL ADSORBENTS AND PROTECTIVES	KAOPECTATE
PA	D6A	DRUGS TO TREAT CHRONIC INFLAMM DISEASES OF THE COLON	REMICADE
D	D6C	IRRITABLE BOWEL SYND. AGENT,5HT-3 ANTAGONIST-TYPE	LOTRONEX
A	D6D	ANTIDIARRHEALS	LOMOTIL
A	D6H	HEMORRHOIDAL AGENTS	*
A	D6S	LAXATIVES AND CATHARTICS	DOCUSATE SODIUM
A	D7A	BILE SALTS	DECHOLIN
A	D7B	CHOLERETICS	KINEVAC
D	D7C	HEPATIC DIAGNOSTICS	
PA	D7J	HEPATIC DYSFUNCTION PREVENTIVE/THERAPY AGENTS	*
A	D7L	BILE SALT INHIBITORS	QUESTRAN
D	D7T	BILIARY DIAGNOSTICS	
D	D7U	BILIARY DIAGNOSTICS, RADIOPAQUE	
A	D8A	PANCREATIC ENZYMES	PANCREASE

D	D8B	PANCREATIC DIAGNOSTICS	
A	D9A	AMMONIA INHIBITORS	BUPHENYL

F MALE GENITAL SYSTEM

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
PA	F1A	ANDROGENIC AGENTS	DEPO-TESTOSTERONE
PA	F2A	DRUGS TO TREAT IMPOTENCY	MUSE

G FEMALE GENITAL SYSTEM

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
D	G0U	UTERINE RADIOPAQUE DIAGNOSTIC AGENTS	
D	G1A	ESTROGENIC AGENTS	PREMARIN
D	G1B	ESTROGEN/ANDROGEN COMBINATION PREPARATIONS	ESTRATEST
D	G2A	PROGESTATIONAL AGENTS	PROVERA
D	G3A	OXYTOCICS	PITOCIN
D	G8A	CONTRACEPTIVES, ORAL	LOESTRIN FE
D	G8B	CONTRACEPTIVES, IMPLANTABLE	NORPLANT SYSTEM
D	G8C	CONTRACEPTIVES, INJECTABLE	DEPO-PROVERA
PA	G8D	ABORTIFACIENT, PROGESTERONE RECEPTOR ANTAGONIST TYPE	MIFEPREX
D	G9A	CONTRACEPTIVES, INTRAVAGINAL	CONCEPTROL GEL

H NERVOUS SYSTEM (EXCEPT AUTONOMIC)

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
A	H0A	LOCAL ANESTHETICS	LIDOCAINE
D	H0E	AGENTS TO TREAT MULTIPLE SCLEROSIS	COPAXONE
D	H1U	CEREBRAL SPINAL RADIOPAQUE DIAGNOSTICS	
PA	H2A	CENTRAL NERVOUS SYSTEM STIMULANTS	CYLERT
D	H2B	GENERAL ANESTHETICS, INHALANT	HALOTHANE
D	H2C	GENERAL ANESTHETICS, INJECTABLE	PENTOTHAL
A	H2D	BARBITURATES (Phenobarbital Only)	NEMBUTAL
A	H2E	NON-BARBITURATE, SEDATIVE-HYPNOTICS	AMBIEN
A	H2F	ANTIANXIETY DRUGS	DIAZEPAM
A	H2G	ANTI-PSYCHOTICS, PHENOTHIAZINES	PERPHENAZINE
A	H2H	MONOAMINE OXIDASE (MAO) INHIBITORS	*
A	H2J	ANTIDEPRESSANTS O.U.	*
A	H2K	ANTIDEPRESSANT COMBINATIONS O.U.	*
A	H2L	ANTI-PSYCHOTICS, NON-PHENOTHIAZINES	HALDOL
A	H2M	ANTI-MANIA DRUGS	LITHIUM CARBONATE
A	H2R	ANTI-PRURITICS	*
A	H2S	SEROTONIN SPEC REUPTAKE INHIBITOR (SSRI'S)	PROZAC
D	H2T	ALCOHOL-SYSTEMIC USE	
A	H2U	TRICYCLIC ANTIDEPRESSANTS & RELATED NON-SRI	AMITRIPTYLINE HCL
PA	H2V	ANTI-NARCOLEPSY/ANTI-HYPERKINESIS AGENTS	METHYLPHENIDATE HCL
A	H2W	TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATIONS	ETRAFON 2-10
A	H2X	TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATION	LIMBITROL
A	H2Y	TRICYCLIC ANTIDEPRESSANT/NON-PHENOTHIAZINE COMB.	*
A	H2Z	BENZODIAZEPINE ANTAGONISTS	ROMAZICON
A	H3A	ANALGESICS, NARCOTICS	HYDROCODONE/APAP
A	H3C	ANALGESICS, NON-NARCOTICS	DURACLON
A	H3D	SALICYLATE ANALGESICS	ASPIRIN, BUTALBITAL COMPOUND
A	H3E	ANALGESIC/ANTIPYRETICS, NON-SALICYLATE	APAP, BUTALBITAL/APAP
PA	H3F	ANTIMIGRAINE PREPARATIONS	IMITREX
A	H3G	MISCELLANEOUS ANALGESICS	*
D	H3H	ANALGESICS NARCOTIC, ANESTHETIC ADJUNCT	FENTANYL CITRATE
A	H3T	NARCOTIC ANTAGONISTS	NALOXONE
A	H4B	ANTICONVULSANTS	NEURONTIN
D	H4T	HALLUCINOGENS	*
D	H5A	NEUROTONICS/CEREBROVASCULAR ACCIDENT AGENTS	*
A	H5B	NEUROPATHIC AGENTS	*

PA	H6A	ANTIPARKINSONISM DRUGS, OTHER	SINEMET CR
A	H6B	ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC	BENZTROPINE MESYLATE
A	H6C	ANTITUSSIVE, NON-NARCOTIC	ROBITUSSIN
A	H6E	EMETICS	IPECAC
A	H6H	SKELETAL MUSCLE RELAXANTS	FLEXERIL
D	H6I	AMYOTROPHIC LATERAL SCLEROSIS AGENTS	RILUTEK
A	H6J	ANTI-EMETICS	MECLIZINE HCL
D	H6L	MOVEMENT DISORDERS (DRUG THERAPY)	*
A	H6N	ANTITUSSIVES, NARCOTIC	*
A	H7A	TRICYCLIC ANTIDEPRESSANT/PHENO/BENZO COMB.	*
A	H7B	ALPHA-2 RECEPTOR ANTAGONISTS	REMERON
A	H7C	SEROTONIN-NOREPINEPHRINE REUPTAKE INHIB (SNRIS)	EFFEXOR
PA	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	WELLBUTRIN
A	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIB (SARIS)	TRAZODONE
A	H7F	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR (SEL-NARI)	*
A	H7G	SEROTONIN AND DOPAMINE REUPTAKE INHIB (SDRIS)	*
A	H7H	SSRI & ERGOT COMB. (SSRI/ERGOT COMB.)	*
A	H7I	ANTIDEPRESSANT O.U./BARB/BELLADONNA COMBINATIONS	*
A	H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	NARDIL
A	H7K	MAOIS - A SELECTIVE & REVERSIBLE (RIMA)	*
A	H7L	MAOI N-S & IRREVERSIBLE/PHENOTHIAZINE COMBINATIONS	*
A	H7M	ANTIDEPRESSANT O.U./CARBAMATE ANXIOLYTIC COMBINATIONS	*
PA	H7N	SMOKING DETERRENTS, OTHER	ZYBAN

J AUTONOMIC NERVOUS SYSTEM

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
A	J1A	PARASYMPATHETIC AGENTS	URECHOLINE
PA	J1B	CHOLINESTERASE INHIBITORS	COGNEX
A	J2A	BELLADONNA ALKALOIDS	HYOSCYAMINE
A	J2B	ANTICHOLINERGICS, QUATERNARY	CLIDINIUM W/CHLORDIAZEPOXIDE
A	J2C	ANTICHOLINERGICS, OTHER	*
A	J2D	ANTICHOLINERGICS/ANTISPASMODICS	DICYCLOMINE HCL
D	J3A	GANGLIONIC STIMULANTS	NICOTROL
D	J4A	GANGLIONIC BLOCKING AGENTS	*
D	J5A	ADRENERGIC AGENTS, CATECHOLAMINES	DOPAMINE
D	J5B	ADRENERGICS, AROMATIC NON-CATECHOLAMINES (AMPHETAMINE)	DEXEDRINE
A	J5C	ADRENERGIC AGENTS, NON-AROMATIC	*
A	J5D	BETA-ADRENERGIC AGENTS	ALBUTEROL
A	J5E	SYMPATHOMIMETIC NASAL DECONGESTANTS	SUDAFED
A	J5F	ANAPHYLAXIS THERAPY AGENTS	ANA-KIT
A	J5H	ADRENERGIC VASOPRESSOR AGENTS	PROAMATINE
A	J7A	ALPHA/BETA ADRENERGIC BLOCKING AGENTS	TRANDATE
A	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	DIBENZYLINE
PA	J7C	BETA-ADRENERGIC BLOCKING AGENTS	PROPRANOLOL HCL
PA	J7E	ALPHA-ADRENERGIC BLOCKING AGENT/THIAZIDE COMBINATION	MINIZIDE 1
D	J8A	ANOREXIC AGENTS	PHENTERMINE
A	J9A	INTESTINAL MOTILITY STIMULANTS	METOCLOPRAMIDE HCL
PA	J9B	ANTISPASMODIC AGENTS	BEL-PHEN-ERGOT S

L SKIN/SUBCUTANEOUS TISSUE

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
A	L0B	TOPICAL/MUCOUS MEMBRANE/SUB-Q ENZYME PREPS	SANTYL
PA	L0C	DIABETIC ULCER PREPARATIONS, TOPICAL	REGRANEX
PA	L1A	ANTIPSORIATIC AGENTS, SYSTEMIC	SORIATANE
D	L1B	ACNE AGENTS, SYSTEMIC	ACCUTANE
D	L1C	HYPERTRICHOTIC AGENTS, SYSTEMIC	PROPECIA
A	L2A	EMOLLIENTS	LAC-HYDRIN
A	L3A	PROTECTIVES	ZINC OXIDE
A	L3P	ANTIPRURITICS, TOPICAL	BENADRYL CREAM
A	L4A	ASTRINGENTS	WITCH HAZEL

D	L5A	KERATOLYTICS	DESQUAM-X 10%
D	L5B	SUNSCREENS	PRESUN SPF 15
D	L5C	ABRASIVES	BRASIVOL
D	L5D	DEPILATORIES	SURGEX
D	L5E	ANTISEBORRHEIC AGENTS	SELSUN BLUE
PA	L5F	ANTIPSORIATIC AGENTS, TOPICAL	TAZORAC GEL
D	L5H	ACNE AGENTS, TOPICAL	*
A	L6A	IRRITANTS/COUNTER-IRRITANTS	CAPSAICIN
D	L7A	SHAMPOOS	
D	L8A	DEODORANTS	
D	L8B	ANTIPERSPIRANTS	
A	L9A	MISCELLANEOUS TOPICAL AGENTS	POLYTAR SOAP
D	L9B	VITAMIN A DERIVATIVES	RETIN-A
D	L9C	HYPOPIGMENTATION AGENTS	SOLAQUIN
D	L9D	TOPICAL HYPERPIGMENTATION AGENTS	OXSORALEN
D	L9F	COSMETIC/SKIN COLORING/DYE AGENTS, TOPICAL	VITADYE
D	L9G	SKIN TISSUE REPLACEMENT	APLIGRAF
D	L9I	VITAMIN A DERIVATIVES, TOPICAL COSMETIC AGENTS	RENOVA

M BLOOD

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
PA	M0A	BLOOD COMPONENTS	*
PA	M0B	PLASMA PROTEINS	PLASMANATE 5%
PA	M0C	BLOOD FACTORS, MISCELLANEOUS	*
A	M0D	PLASMA EXPANDERS	DEXTRAN 40
PA	M0E	ANTIHEMOPHILIC FACTORS	KOATE-HP
PA	M0F	FACTOR IX PREPARATIONS	KONYNE 80
PA	M0G	ANTIPORPHYRIA FACTORS	PANHEMATIN
PA	M0H	FACTOR II PREPARATIONS	*
PA	M0R	BLOOD ALBUMIN PREPARATIONS	*
PA	M0S	SYNTHETIC BLOOD PREPARATIONS	*
D	M0U	BLOOD VOLUME DIAGNOSTICS	*
A	M3A	OCCULT BLOOD TESTS	GASTROCCULT
PA	M3B	BLOOD UREA NITROGEN TESTS	AZOSTIX REAGENT
PA	M4A	BLOOD SUGAR DIAGNOSTICS	ONE TOUCH TEST STRIPS
A	M4B	IV FAT EMULSIONS	LIPOSYN II
D	M4E	LIPOTROPICS	ZOCOR
D	M4G	HYPERGLYCEMICS	GLUCAGON
D	M4H	AGENTS THAT AFFECT CELLULAR LIPIDS	LIPITOR
A	M9A	TOPICAL HEMOSTATICS	THROMBOSTAT
A	M9D	ANTIFIBRINOLYTIC AGENTS	AMINOCAPROIC ACID
A	M9E	THROMBIN INHIBITORS, HIRUDIN TYPE AGENTS	REFLUDAN
A	M9F	THROMBOLYTIC ENZYMES	ABBOKINASE
A	M9J	CITRATES AS ANTICOAGULANTS	CITRATE PHOS DEXTROSE
A	M9K	HEPARIN PREPARATIONS	HEPARIN
A	M9L	ORAL ANTICOAGULANTS, COUMARIN TYPE	COUMADIN
A	M9M	ORAL ANTICOAGULANTS, INDANDIONE TYPE	MIRADON
PA	M9P	PLATELET AGGREGATION INHIBITORS	TICLID
A	M9R	COAGULANTS	PROTAMINE
PA	M9S	HEMORRHEOLOGIC AGENTS	TRENTAL

N BONE MARROW

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
PA	N1A	ERYTHROID DEPRESSANTS	*
PA	N1B	HEMATINICS, OTHER	EPOGEN
D	N1C	LEUKOCYTE (WBC) STIMULANTS	NEUPOGEN
PA	N1D	PLATELET REDUCING AGENTS	AGRYLIN
PA	N1E	PLATELET PROLIFERATION STIMULANTS	NEUMEGA

P ENDOCRINE SYSTEM (EXCEPT GONADS)

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
D	P0A	FERTILITY PREPARATIONS	CLOMIPHENE CITRATE
D	P0B	FOLLICLE STIMULATING HORMONES	HUMEGON
D	P0C	PREGNANCY FACILITATING/MAINTAINING AGENTS, HORMONAL	CRINONE GEL
D	P1A	GROWTH HORMONES	GENOTROPIN
D	P1B	SOMATOSTATIC AGENTS	SANDOSTATIN
D	P1C	LUTEINIZING HORMONES	*
D	P1D	THYROTROPIC HORMONES	*
D	P1E	ADRENOCORTICOTROPHIC HORMONES	ACTHAR
D	P1F	PITUITARY SUPPRESSIVE AGENTS	DANOCRINE
D	P1G	ADRENAL STEROID INHIBITORS	CYTADREN
D	P1H	GROWTH HORMONE RELEASING HORMONE	GEREF
D	P1L	LUTEINIZING HORMONE RELEASING-HORMONE	FACTREL
D	P1M	LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS	SUPPRELIN
D	P1P	LHRH/GNRH AGONIST PITUITARY SUPPRESSANTS-C PREC PUBERTY	LUPRON DEPOT-PED
D	P1U	METABOLIC FUNCTION DIAGNOSTICS	
D	P2B	ANTIDIURETIC AND VASOPRESSOR HORMONES	DDAVP
D	P2Z	POSTERIOR PITUITARY PREPARATIONS	*
A	P3A	THYROID HORMONES	SYNTHYROID
D	P3B	THYROID FUNCTION DIAGNOSTIC AGENTS	THYREL TRH
D	P3L	ANTITHYROID PREPARATIONS	PROPYLTHIOURACIL
PA	P4A	PARATHYROID HORMONES	*
PA	P4L	BONE RESORPTION SUPPRESSION AGENTS	FOSAMAX
A	P5A	GLUCOCORTICOIDS	PREDNISONE
A	P5S	MINERALOCORTICOIDS	FLORINEF ACETATE
A	P5T	ALDOSTERONE ANTAGONISTS	*
D	P6A	PINEAL HORMONE AGENTS	MELATONIN

Q EAR, EYE, NOSE, RECTUM, TOPICAL, VAGINA, SPECIAL SENSES

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
A	Q0A	TOPICAL PREPARATIONS, NON-MEDICINAL	*
A	Q1A	TOPICAL EAR PREPARATIONS	*
D	Q2A	OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS	VISUDYNE
D	Q2U	EYE DIAGNOSTIC AGENTS	
A	Q3A	RECTAL PREPARATIONS	PROCTOFOAM-HC
A	Q3B	RECTAL/LOWER BOWEL PREP, GLUCOCORTICOID, NON-HEMO	CORTIFOAM
A	Q3D	HEMORRHOIDAL PREPARATIONS	PREPARATION H
A	Q3H	HEMORRHOIDAL PREPARATIONS, LOCAL ANESTHETICS	NUPERCAINAL OINT
A	Q3S	LAXATIVES, LOCAL/RECTAL	FLEET ENEMA
PA	Q4A	VAGINAL PREPARATIONS	PROSTIN E2
PA	Q4B	VAGINAL ANTISEPTICS	BETADINE DOUCHE
PA	Q4F	VAGINAL ANTIFUNGALS	CLOTRIMAZOLE-7
PA	Q4G	VAGINAL ANTIFUNGALS-ANTIBACTERIAL AGENTS	*
D	Q4K	VAGINAL ESTROGEN PREPARATIONS	ESTRACE CREAM
D	Q4L	VAGINAL LUBRICANT PREPARATIONS	ASTROGLIDE
PA	Q4R	VAGINAL ANTIPARASITICS	*
PA	Q4S	VAGINAL SULFONAMIDES	SULFANILAMIDE 15%
PA	Q4W	VAGINAL ANTIBIOTICS	CLEOCIN
D	Q5A	TOPICAL PREPARATIONS, MISCELLANEOUS	SHUR-CLENS
A	Q5B	TOPICAL PREPARATIONS, ANTIBACTERIALS	BETADINE
D	Q5C	TOPICAL PREPARATIONS, HYPERTRICHOTIC AGENTS	ROGAINE
PA	Q5D	TOPICAL PREPARATIONS, ANTIPSORIATICS	*
A	Q5E	TOPICAL ANTIINFLAMMATORY, NON-STEROIDAL	*
A	Q5F	TOPICAL ANTIFUNGALS	LOTRIMIN
A	Q5G	TOPICAL ANTIFUNGALS-ANTIBACTERIALS AGENTS	DIABET-X
A	Q5H	TOPICAL LOCAL ANESTHETICS	LIDOCAINE
PA	Q5I	TOPICAL VEINOTONIC/VASCULOPROTECTOR	*
D	Q5J	TOPICAL HORMONAL, OTHERWISE UNSPECIFIED	*
PA	Q5N	TOPICAL ANTINEOPLASTICS	EFUDEX 5%
A	Q5O	TOPICAL ANTIEDEMA/ANTIINFLAMMATORY AGENTS	*
A	Q5P	TOPICAL ANTIINFLAMMATORY PREPARATIONS	TRIAMCINOLONE

			ACETONIDE
A	Q5Q	TOPICAL ANTIBIO-ANTIBAC-ANTIFUNG-ANTIINFLAMM AGENTS	*
A	Q5R	TOPICAL ANTIPARASITICS	LINDANE
A	Q5S	TOPICAL SULFONAMIDES	SILVADENE
A	Q5V	TOPICAL ANTIVIRALS	ZOVIRAX
A	Q5W	TOPICAL ANTIBIOTICS	NEOSPORIN
A	Q5X	TOPICAL ANTIBIOTICS/ANTIINFLAMMATORY, STEROIDAL	CORTISPORIN
D	Q5Y	TOPICAL ANDROGENIC AGENTS	DHEA
A	Q6A	EYE PREPARATIONS, MISCELLANEOUS	REFRESH P.M.
A	Q6B	EYE ANTIINFECTIVES (RX ONLY)	BETADINE EYE SOL
A	Q6C	EYE VASOCONSTRICTORS (RX ONLY)	PHENYLEPHRINE HCL
A	Q6D	EYE VASOCONSTRICTORS (OTC ONLY)	NAPHCON-A
A	Q6E	EYE IRRIGATIONS	BSS EYE SOLUTION
D	Q6F	CONTACT LENS PREPARATIONS	LENS PLUS
A	Q6G	MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS	TRUSOPT
A	Q6H	EYE LOCAL ANESTHETICS	TETRACAINE
A	Q6I	EYE ANTIBIOTIC-CORTICOID COMBINATIONS	TOBRADEX
A	Q6J	MYDRIATICS	CYCLOGYL
A	Q6K	OPHTHALMIC-OTIC COMBINATIONS	*
A	Q6P	EYE ANTIINFLAMMATORY AGENTS	ACULAR
A	Q6R	EYE ANTIHISTAMINES	PATANOL
A	Q6S	EYE SULFONAMIDES	SULFACETAMIDE SODIUM
A	Q6T	ARTIFICIAL TEARS	ARTIFICIAL TEARS
A	Q6U	OPHTHALMIC MAST CELL STABILIZERS	CROMOLYN SODIUM
A	Q6V	EYE ANTIVIRALS	VIROPTIC
A	Q6W	EYE ANTIBIOTICS	GENTAMICIN SULFATE
A	Q6Y	EYE PREPARATIONS, MISCELLANEOUS (OTC ONLY)	LACRI-LUBE S.O.P.
A	Q6Z	EYE ANTIINFECTIVES, (OTC ONLY)	STYE
A	Q7A	NOSE PREPARATIONS, MISCELLANEOUS (RX ONLY)	ATROVENT
A	Q7B	NOSE PREPARATIONS, MISCELLANEOUS ANTIINFECTIVES	*
A	Q7C	NOSE PREPARATIONS, VASOCONSTRICTORS (RX ONLY)	TYZINE
A	Q7D	NOSE PREPARATIONS, VASOCONSTRICTORS (OTC ONLY)	AFRIN
A	Q7E	NASAL ANTIHISTAMINE	ASTELIN
A	Q7F	NASAL PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS	*
A	Q7G	NASAL PREPARATIONS, IRRITANTS/COUNTER-IRRITANTS	*
A	Q7H	NASAL MAST CELL STABILIZERS AGENTS	NASALCROM
A	Q7P	NOSE PREPARATIONS, ANTIINFLAMMATORY	BECONASE AQ
A	Q7W	NOSE PREPARATIONS, ANTIBIOTICS	BACTROBAN
A	Q7Y	NOSE PREPARATIONS, MISCELLANEOUS (OTC ONLY)	NASAL SPRAY
A	Q8A	EAR PREPARATIONS, MISCELLANEOUS (RX ONLY)	OTO CARE HC
A	Q8B	EAR PREPARATIONS, MISCELLANEOUS ANTIINFECTIVES	DOMEBORO
A	Q8F	EAR PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS	CIPRO HC
A	Q8H	EAR PREPARATIONS, LOCAL ANESTHETICS	AURALGAN
A	Q8P	EAR PREPARATIONS, ANTIINFLAMMATORY	EARSOL-HC
D	Q8R	EAR PREPARATIONS, EAR WAX REMOVERS	CERUMENEX
A	Q8W	EAR PREPARATIONS, ANTIBIOTICS	NEOMYCIN/POLYMYXIN/HC
A	Q8Y	EAR PREPARATIONS, MISCELLANEOUS (OTC ONLY)	SWIM EAR DROPS
A	Q9A	UROLOGICAL IRRIGATIONS	*
D	Q9B	BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS	FLOMAX

R KIDNEY/URINARY TRACT

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
A	R1A	URINARY TRACT ANTISPASMODIC AGENTS	OXYBUTYNIN CHLORIDE
PA	R1B	OSMOTIC DIURETICS	MANNITOL
PA	R1C	INORGANIC SALT DIURETICS	AMMONIUM CHLORIDE
PA	R1D	MERCURIAL DIURETICS	*
PA	R1E	CARBONIC ANHYDRASE INHIBITORS	DARANIDE
PA	R1F	THIAZIDE DIURETICS AND RELATED AGENTS	CHLOROTHIAZIDE
PA	R1H	POTASSIUM SPARING DIURETICS	MIDAMOR
PA	R1J	AMINOURACIL DIURETICS	*
PA	R1K	MISCELLANEOUS DIURETICS	ISMOTIC 45%
PA	R1L	POTASSIUM SPARING DIURETICS IN COMBINATION	DYAZIDE

PA	R1M	LOOP DIURETICS	FUROSEMIDE
D	R1R	URICOSURIC AGENTS	PROBENECID
A	R1S	URINARY PH MODIFIERS	RENACIDIN
A	R1T	RENAL COMPETERS	*
D	R1U	RENAL FUNCTION DIAGNOSTIC AGENTS	
D	R2U	URINARY TRACT RADIOPAQUE DIAGNOSTICS	
PA	R3U	URINE GLUCOSE TEST AIDS	CHEMSTRIP UG
PA	R3V	MISCELLANEOUS URINE TEST AIDS	NITRAZINE PAPER
PA	R3W	URINE ACETONE TEST AIDS	ACETONE TEST STRIP
PA	R3Y	URINE MULTIPLE TEST AIDS	MULTISTIX 10 SG
PA	R3Z	URINE GLUC-ACET COMB.TST, STRIP	CHEMSTRIP UGK
PA	R4A	KIDNEY STONE AGENTS	THIOLA
PA	R5A	URINARY TRACT ANESTHETIC/ANALGESIC AGENTS	PHENAZOPYRIDINE
PA	R5B	URINARY TRACT ANALGESIC AGENTS	ELMIRON

S LOCOMOTOR SYSTEM

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
D	S2A	COLCHICINE	COL-PROBENECID
A	S2B	NSAIDS, CYCLOOXYGENASE INHIBITOR TYPE	IBUPROFEN
A	S2C	GOLD SALTS	RIDAURA
A	S2G	DRUGS ACTING ON BONE DISORDERS	*
PA	S2H	ANTI-INFLAMM/ANTIARTHRITIC AGENTS, MISCELLANEOUS	SYNVISC
PA	S2I	ANTI-INFLAMM, PYRIMIDINE SYNTHESIS INHIBITOR	ARAVA
PA	S2J	ANTI-INFLAMM, TUMOR NECROSIS FACTOR INHIBITOR	ENBREL
PA	S2N	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS	RHEUMATREX
D	S7A	NEUROMUSCULAR BLOCKING AGENTS	BOTOX
A	S7B	SKELETAL MUSCLE, OTHERS	*

U MISCELLANEOUS DRUGS AND PHARMACEUTICAL ADJUVANTS

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
D	U5A	HOMEOPATHIC DRUGS	INSOMNIA FORMULA
D	U5B	HERBAL DRUGS	GINSENG
D	U5F	ANIMAL/HUMAN DERIVED AGENTS	NEATSFOOT
A	U6A	PHARMACEUTICAL ADJUVANTS, TABLETING AGENTS	STARCH
A	U6B	PHARMACEUTICAL ADJUVANTS, COATING AGENTS	*
A	U6E	OINTMENT/CREAM BASES	PETROLEUM JELLY
A	U6F	HYDROPHILIC CREAM/OINTMENT BASES	UNIBASE OINTMENT
A	U6H	SOLVENTS	ISOPROPYL ALCOHOL
A	U6N	VEHICLES	SORBITOL
A	U6S	PROPELLANTS	*
A	U6W	BULK CHEMICALS, O.U.	PIROXICAM, BULK
A	U7A	SUSPENDING AGENTS	GELATIN
A	U7D	SURFACTANTS	LINDORA LIQUID
A	U7H	ANTIOXIDANTS	SULFUR
A	U7J	CHELATING AGENTS	GLUTATHIONE
A	U7K	FLAVORING AGENTS	ANISE
A	U7N	SWEETENERS	GLUCOSE
A	U7P	PERFUMES	LAVENDER OIL
A	U7Q	COLORING AGENTS	CARAMEL
A	U7Z	BONDING/CATALYST AGENTS	

V NEOPLASMS

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
PA	V1A	ALKYLATING AGENTS	CYTOXAN
PA	V1B	ANTIMETABOLITES	FLUOROURACIL
PA	V1C	VINCA ALKALOIDS	VINBLASTINE SULFATE
PA	V1D	ANTIBIOTIC ANTINEOPLASTICS	MUTAMYCIN
PA	V1E	STEROID ANTINEOPLASTICS	MEGACE
PA	V1F	MISCELLANEOUS ANTINEOPLASTICS	VEPESID

PA	V1G	RADIOACTIVE THERAPEUTIC AGENTS	METASTRON
PA	V1I	CHEMOTHERAPY ANTIDOTES	MESNEX
PA	V1J	ANTIANDROGENIC AGENTS	PROSCAR
PA	V1K	ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES	RITUXAN
PA	V1N	SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)	TARGRETIN
D	V1O	ANTINEOPLASTIC LHRH AGONISTS, PITUITARY SUPPRESSANT	ZOLADEX
PA	V2A	NEOPLASM MONOCLONAL DIAGNOSTIC AGENTS	ONCOSCINT CR/OV

W ANTI-INFECTING AGENTS

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
A	W1A	PENICILLINS	AUGMENTIN
A	W1B	CEPHALOSPORINS	CEPHALEXIN
A	W1C	TETRACYCLINES	DOXYCYCLINE HYCLATE
A	W1D	MACROLIDES	ERY-TAB
A	W1E	CHLORAMPHENICOL AND DERIVATIVES	CHLORAMPHENICOL
A	W1F	AMINOGLYCOSIDES	GENTAMICIN
A	W1G	ANTITUBERCULAR ANTIBIOTICS	RIFADIN
A	W1H	AMINOCYCLITOLS	TROBICIN W/DILUENT
A	W1J	VANCOMYCIN AND DERIVATIVES	VANCOMYCIN HCL
A	W1K	LINCOSAMIDES	CLINDAMYCIN HCL
A	W1L	TOPICAL ANTIBIOTICS	BACITRACIN STER POWDER
A	W1M	STREPTOGRAMINS	SYNERCID
A	W1N	POLYMYXIN AND DERIVATIVES	POLYMIXIN B
A	W1O	OXAZOLIDONES	ZYVOX
A	W1P	OXABETA-LACTAMS	LORABID
A	W1Q	QUINOLONES	CIPRO
A	W1R	BETA-LACTAMASE INHIBITORS	*
A	W1S	THIENAMYCINS	PRIMAXIN I.V.
A	W1V	STEROIDAL ANTIBIOTICS	*
A	W2A	ABSORBABLE SULFONAMIDES	GANTANOL
A	W2B	NON-ABSORBABLE SULFONAMIDES	*
A	W2E	ANTITUBERCULAR AGENTS	ISONIAZID
A	W2F	NITROFURAN DERIVATIVES	PROSED/DS
A	W2G	ANTIBACTERIAL CHEMOTHERAPEUTIC AGENTS, MISC.	TRIMETHOPRIM
A	W2Y	MISCELLANEOUS ANTIINFECTIVES	DIMETHYL SULFOXIDE
A	W3A	ANTIFUNGAL ANTIBIOTICS	NYSTATIN
A	W3B	ANTIFUNGAL AGENTS	DIFLUCAN
A	W4A	ANTIMALARIAL DRUGS	QUININE SULFATE
D	W4C	AMEBACIDES	HUMATIN
A	W4E	TRICHOMONACIDES	METRONIDAZOLE
D	W4F	MISCELLANEOUS ANTIINFECTIVES (ANTIPARASITICS)	*
D	W4K	MISCELLANEOUS ANTIPROTOZOAL DRUGS	PENTAMIDINE
D	W4L	ANTHELMINTICS	ALBENZA
D	W4M	TOPICAL ANTIPARASITICS	SULFUR
D	W4N	INSECT REPELLENTS	*
D	W4P	ANTILEPROTICS	LAMPRENE
D	W4Q	INSECTICIDES	BEDDING SPRAY
PA	W5A	ANTIVIRALS	VALTREX
A	W5B	ANTIVIRALS, HIV-SPECIFIC	RETROVIR
A	W5C	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS	CRIXIVAN
PA	W5D	ANTIVIRAL MONOCLONAL ANTIBODIES	SYNAGIS
PA	W5E	HEPATITIS A TREATMENT AGENTS	*
PA	W5F	HEPATITIS B TREATMENT AGENTS	EPIVIR HBV
PA	W5G	HEPATITIS C TREATMENT AGENTS	REBETRON 1000
D	W7B	EXANTHEMATOUS AND TUMOR CAUSING VIRUS VACCINES	RECOMBOVAX HB
D	W7C	INFLUENZA VIRUS VACCINES	OMNIHIB
D	W7F	MUMPS AND RELATED VIRUS VACCINES	MUMPSVAX
D	W7H	ENTERIC VIRUS VACCINES	ORIMUNE
D	W7I	IMMUNOSTIMULANTS, BACTERIAL	*
D	W7J	ARTHROPOD-BORNE AND OTHER NEUROTOXIC VIRUS VACCINES	RABIES VACC
A	W7K	ANTISERA	H-BIG
D	W7L	GRAM POSITIVE COCCI VACCINES	PNU-IMUN
D	W7M	GRAM NEGATIVE BACILLI (NON-ENTERIC) VACCINES	TYPHOID VACC

D	W7N	TOXIN PRODUCING BACTERIA VACCINES AND TOXOIDS	CHOLERA VACC
D	W7O	GRAM POSITIVE ROD VACCINES	*
D	W7P	RICKETTSIAL VACCINES	*
D	W7Q	GRAM NEGATIVE COCCI VACCINES	MENOMUNE
D	W7R	SPIROCHETE VACCINES	LYMERIX
A	W7S	ANTIVENINS	ANTIVENIN, POLYVALENT
D	W7T	ANTIGENIC SKIN TESTS	TUBERCULINE TINE TEST
D	W7U	HYMENOPTERA EXTRACTS	ALBAY-MIX VESPID
D	W7V	RHUS EXTRACTS	SIMPLE SKIN DISORDERS NO.14
D	W7W	MISCELLANEOUS THERAPEUTIC ALLERGENIC EXTRACTS	POLLEN EXTRACT
D	W7X	BACTERIA, AEROBIC/ANAEROBIC AGENTS	*
D	W7Y	FUNGI/YEAST PREPARATIONS	*
D	W7Z	COMBINATION VACCINE AND TOXOID PREPARATIONS	M-M-R II
A	W8A	HEAVY METAL ANTISEPTICS	MERCURY
A	W8B	SURFACE ACTIVE AGENTS	ZEPHIRAN
A	W8C	IODINE ANTISEPTICS	IODINE TINCTURE
A	W8D	OXIDIZING AGENTS	HYDROGEN PEROXIDE
A	W8E	ANTISEPTICS, GENERAL	ALCOHOL WIPES
A	W8F	IRRIGANTS	SODIUM CHLORIDE, .9%
D	W8G	MISCELLANEOUS ANTISEPTICS	CIDEX
D	W8H	MOUTHWASHES	CEPACOL
A	W8J	MISCELLANEOUS ANTIBACTERIAL AGENTS	GLYCINE, 1.5%
D	W8T	PRESERVATIVES	FORMALDEHYDE

Z BODY AS A WHOLE

STATUS	GC3	THERAPEUTIC CLASS DESCRIPTION	REPRESENTATIVE DRUG
D	Z1A	HISTAMINE PREPARATIONS	HISTATROL INTRADERMAL
D	Z1C	SEROTONIN AND DERIVATIVES	*
D	Z1D	ENZYME REPLACEMENTS (UBIQUITOUS ENZYMES)	CEREDASE
D	Z1E	ANTIOXIDANT AGENTS	ANTIOXIDANT A, C & E
PA	Z1F	IMMUNE SYSTEM CELL GROUPS	*
A	Z2A	ANTIHISTAMINES	DIPHENHYDRAMINE HCL
PA	Z2C	ANTISEROTONIN DRUGS	*
A	Z2D	HISTAMINE H2 INHIBITORS	*
PA	Z2E	IMMUNOSUPPRESIVES	SANDIMMUNE
A	Z2F	MAST CELL STABILIZERS	INTAL
PA	Z2G	IMMUNOMODULATORS	INTRON A
D	Z2H	SYSTEMIC ENZYME INHIBITORS	PROLASTIN
D	Z3G	MISCELLANEOUS AGENTS	KUTAPRESSIN
PA	Z4A	PROSTOGLANDINS	*
A	Z4B	LEUKOTRIENE RECEPTOR ANTAGONISTS	ACCOLATE
D	Z4C	THROMBOXANE A2 INHIBITORS	*
D	Z9A	UNIDENTIFIED DRUGS	*
D	Z9D	DIAGNOSTIC PREPARATIONS, OU	PROVOCHOLINE